		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045815

Facility Name: CHICAGO RIDGE NURSING CENTER

Address: 10602 SOUTHWEST HIGHWAY (Number) CHICAGO RIDGE (City) 60415 (Zip Code)

County: COOK

Telephone Number: (773) 252-3208 **Fax #** (773) 252-3688

IDPA ID Number: 364420067

Date of Initial License for Current Owners: 11/01/01

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Sanford B Alper **Telephone Number:** (847) 580-4100

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Sanford B Alper - Principal

(Firm Name & Address) Kessler, Orlean, Silver & Company, P.C.
1101 Lake Cook Rd, Suite C, Deerfield, Illinois 60015

(Telephone) (847) 580-4100 Fax # (847) 580-4199

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number CHICAGO RIDGE NURSING CENTER # 0045815 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 231

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	231	Skilled (SNF)	231	84,315	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	231	TOTALS	231	84,315	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,821	2,821	8
9	SNF/PED					9
10	ICF	56,668	4,945	2,679	64,292	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	56,668	4,945	5,500	67,113	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.60%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/01

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/01 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 38 and days of care provided 2,821

Medicare Intermediary Mutual Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CHICAGO RIDGE NURSING CENTER # 0045815 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	214,996	35,334	10,703	261,033		261,033	0	261,033			1
2	Food Purchase		208,735		208,735		208,735	(367)	208,368			2
3	Housekeeping	141,709	21,589	64,188	227,486		227,486	0	227,486			3
4	Laundry	109,525	15,123		124,648	0	124,648	0	124,648			4
5	Heat and Other Utilities			148,869	148,869		148,869	0	148,869			5
6	Maintenance	109,466	88,603		198,069		198,069	84	198,153			6
7	Other (specify):* See Attached			15,379	15,379		15,379	0	15,379			7
8	TOTAL General Services	575,696	369,384	239,139	1,184,219	0	1,184,219	(283)	1,183,936			8
	B. Health Care and Programs											
9	Medical Director				0		0	0	0			9
10	Nursing and Medical Records	1,886,050	98,592	3,747	1,988,389		1,988,389	0	1,988,389			10
10a	Therapy	13,926		22,040	35,966		35,966	0	35,966			10a
11	Activities	99,930	4,390		104,320		104,320	0	104,320			11
12	Social Services	49,200		6,536	55,736		55,736	0	55,736			12
13	Nurse Aide Training				0		0	0	0			13
14	Program Transportation				0		0	0	0			14
15	Other (specify):*				0		0	0	0			15
16	TOTAL Health Care and Programs	2,049,106	102,982	32,323	2,184,411	0	2,184,411	0	2,184,411			16
	C. General Administration											
17	Administrative	290,089		21,669	311,758		311,758	0	311,758			17
18	Directors Fees				0		0	0	0			18
19	Professional Services			70,331	70,331		70,331	(5,031)	65,300			19
20	Dues, Fees, Subscriptions & Promotions			40,292	40,292	156	40,448	(3,838)	36,610			20
21	Clerical & General Office Expenses	41,580		59,839	101,419		101,419	(8,500)	92,919			21
22	Employee Benefits & Payroll Taxes			395,868	395,868	(156)	395,712	17,355	413,067			22
23	Inservice Training & Education				0		0	0	0			23
24	Travel and Seminar			355	355		355	0	355			24
25	Other Admin. Staff Transportation				0		0	0	0			25
26	Insurance-Prop.Liab.Malpractice			156,324	156,324		156,324	0	156,324			26
27	Other (specify):*				0		0	0	0			27
28	TOTAL General Administration	331,669	0	744,678	1,076,347	0	1,076,347	(14)	1,076,333			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,956,471	472,366	1,016,140	4,444,977	0	4,444,977	(297)	4,444,680			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number CHICAGO RIDGE NURSING CENTER #0045815 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			16,917	16,917		16,917	(12,610)	4,307			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			2,796	2,796		2,796	(11)	2,785			32
33	Real Estate Taxes			369,000	369,000		369,000	0	369,000			33
34	Rent-Facility & Grounds			796,649	796,649		796,649	0	796,649			34
35	Rent-Equipment & Vehicles			1,850	1,850		1,850	0	1,850			35
36	Other (specify):*				0		0	0	0			36
37	**TOTAL Ownership**			1,187,212	1,187,212	0	1,187,212	(12,621)	1,174,591			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		64,751	77,223	141,974		141,974	0	141,974			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			126,473	126,473		126,473	0	126,473			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	64,751	203,696	268,447	0	268,447	0	268,447			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,956,471	537,117	2,407,048	5,900,636	0	5,900,636	(12,918)	5,887,718			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number CHICAGO RIDGE NURSING CENTER # 0045815 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(12,610)	30		9
10	Interest and Other Investment Income	(11)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(367)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(950)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(865)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(11,613)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(23)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(317)	20		28
29	Other-Attach Schedule See Attached Schedule	(7,831)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (34,587)		$ 0	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	21,669		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 21,669		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (12,918)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

CHICAGO RIDGE NURSING CENTER

ID# 0045815

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Collections	$ (4,300)	19	1
2	Franchise Tax	(10)	21	2
3	Non Deductible Dues	(3,521)	20	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(7,831)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CHICAGO RIDGE NURSING CENTER # 0045815 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(367)	0	0	0	0	0	0	0	0	0	0	(367)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	84	0	0	0	0	0	0	0	0	0	84	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(367)	84	0	0	0	0	0	0	0	0	0	(283)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,165)	134	0	0	0	0	0	0	0	0	0	(5,031)	19
20	Fees, Subscriptions & Promotions	(3,838)	0	0	0	0	0	0	0	0	0	0	(3,838)	20
21	Clerical & General Office Expenses	(12,596)	4,096	0	0	0	0	0	0	0	0	0	(8,500)	21
22	Employee Benefits & Payroll Taxes	0	17,355	0	0	0	0	0	0	0	0	0	17,355	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(21,599)	21,585	0	0	0	0	0	0	0	0	0	(14)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(21,966)	21,669	0	0	0	0	0	0	0	0	0	(297)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CHICAGO RIDGE NURSING CENTER # 0045815 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(12,610)	0	0	0	0	0	0	0	0	0	0	(12,610)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11)	0	0	0	0	0	0	0	0	0	0	(11)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(12,621)	0	0	0	0	0	0	0	0	0	0	(12,621)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(34,587)	21,669	0	0	0	0	0	0	0	0	0	(12,918)	45

Facility Name & ID Number CHICAGO RIDGE NURSING CENTER # 0045815 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Marvin Mermelstein	50.00%	Balmoral Home, Inc.	Chicago, IL	Nivram Mngt, Inc.	Chicago, IL	Management
Joseph Mermelstein Trust	25.00%	Central Nursing Home, Inc.	Chicago, IL			
Barry Taerbaum	25.00%	Emerald Park Health Care Center, Inc.	Evergreen Park, IL			
		Sovereign Healthcare, L.L.C.	Chicago, IL			
		RREM Inc. D/B/A Winston Manor Nursing Home	Chicago, IL			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Accounting	$	Nivram Management, Inc.		$ 134	$ 134	1
2	V	21	Bank Charges		Nivram Management, Inc.		159	159	2
3	V	22	Insurance		Nivram Management, Inc.		1,327	1,327	3
4	V	21	Office Expense		Nivram Management, Inc.		158	158	4
5	V	6	Repairs & Maintenance		Nivram Management, Inc.		84	84	5
6	V	21	Supplies		Nivram Management, Inc.		3,127	3,127	6
7	V	21	Franchise Tax		Nivram Management, Inc.		10	10	7
8	V	22	Payroll Taxes		Nivram Management, Inc.		16,028	16,028	8
9	V	21	Telephone		Nivram Management, Inc.		619	619	9
10	V	21	State Replacement Tax		Nivram Management, Inc.		23	23	10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 21,669	$ * 21,669	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CHICAGO RIDGE NURSING CENTER # 0045815 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Henry Mermelstein	Administrative	Administrative	0.00%	225,108	8	9.96%	Salary	$ 24,892	L 17, Col 1	1
2	Louise Mermelstein	Food Service Supp.	Food Serv Sup	0.00%	72,309	14	19.66%	Salary	17,691	L 1, Col 1	2
3	Marvin Mermelstein	Plant Supervisor	Support	50.00%	86,731	4	19.69%	Salary	21,269	L 6, Col 1	3
4	Doreen Mermelstein	Office Manager	Administrative	0.00%	89,937	5	13.15%	Salary	13,623	L 21, Col 1	4
5											5
6	Marvin Mermelstein	Asst. Administrative	Administrative	See Above	130,098	5	19.69%	Salary	31,902	L 17, Col 1	6
7	Joseph Mermelstein	Owner	Administrative	25.00%	69,747	3	26.58%	Salary	25,253	L 17, Col 1	7
8	Barry Taerbaum	Owner	Administrative	25.00%	115,000	218	10.48%	Salary	35,000	L 17, Col 1	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 169,630		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CHICAGO RIDGE NURSING CENTER # 0045815 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Nivram Management, Inc.
Street Address: 2155 W. Pierce
City / State / Zip Code: Chicago, IL 60622
Phone Number: (773) 252-3208
Fax Number: (773) 252-3688

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Accounting	Resident Beds	1,173	6	$ 682	$	231	$ 134	1
2	21	Bank Charges	Resident Beds	1,173	6	805		231	159	2
3	22	Insurance	Resident Beds	1,173	6	6,740		231	1,327	3
4	21	Office Expense	Resident Beds	1,173	6	805		231	159	4
5	6	Repair & Maintenance	Resident Beds	1,173	6	424		231	83	5
6	21	Supplies	Resident Beds	1,173	6	15,880		231	3,127	6
7	21	Franchise Tax	Resident Beds	1,173	6	50		231	10	7
8	22	Payroll Taxes	Resident Beds	1,173	6	81,386		231	16,028	8
9	21	Telephone	Resident Beds	1,173	6	3,145		231	619	9
10	21	State Repacement Tax	Resident Beds	1,173	6	115		231	23	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 110,032	$		$ 21,669	25

Facility Name & ID Number CHICAGO RIDGE NURSING CENTER # 0045815 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Parkway Bank		X	Line of Credit	Demand	11/01	104,000		0	Prime+	2,796	6
7												7
8												8
9	TOTAL Facility Related						$ 104,000	$ 0			$ 2,796	9
	B. Non-Facility Related*											
10	Interest Income Offset										(11)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ (11)	14
15	TOTALS (line 9+line14)						$ 104,000	$ 0			$ 2,785	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number CHICAGO RIDGE NURSING CENTER # 0045815 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	407,806	2
3. Under or (over) accrual (line 2 minus line 1).	$	407,806	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	(38,806)	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	369,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	325,819	8
	1998	325,903	9
	1999	331,718	10
	2000	344,809	11
	2001	358,079	12

Chicago Ridge leasing the building from unrelated party. They are making estimate real estate tax payments on the monthly basis. Therefore we are not accruing any real estate taxes. At the end of the year Chicago Ridge overpayed $38,806 for real estate taxes.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CHICAGO RIDGE NURSING CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0045815

CONTACT PERSON REGARDING THIS REPORT Sanford B Alper

TELEPHONE (847) 580-4100 FAX #: (847) 580-4199

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	24-18-101-025-0000	Nursing Home	$ 262,568.42	$ 262,568.42
2.	24-18-101-039-0000	Nursing Home	$ 95,510.54	$ 95,510.54
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 358,078.96	$ 358,078.96

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number CHICAGO RIDGE NURSING CENTER # 0045815 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 87,480 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3 + Baement

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	73,980		$ 0	1
2					2
3	TOTALS	73,980		$ 0	3

Facility Name & ID Number CHICAGO RIDGE NURSING CENTER # 0045815 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	SIGN			2001	1,419	36	39	36		41	9
10	CARPET			2002	2,240	31	39	29	(2)	29	10
11	ALARM			2002	22,000	118	39	282	164	282	11
12	WASHERS &DRYERS			2002	29,304	657	39	376	(281)	376	12
13	PHONE SYSTEM			2002	10,667	11	39	137	126	137	13
14	A/C SYSTEM			2002	11,200	12	39	144	132	144	14
15	ELECTRICAL REPAIR			2002	3,000	3	39	38	35	38	15
16	LIGHT FIXTURES			2002	10,192	11	39	131	120	131	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number CHICAGO RIDGE NURSING CENTER # 0045815 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 90,022	$ 879		$ 1,173	$ 294	$ 1,178	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CHICAGO RIDGE NURSING CENTER # 0045815 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 19,200	$ 5,355	$ 1,920	$ (3,435)	10 Years	$ 2,880	71
72	Current Year Purchases	24,276	10,683	1,214	(9,469)	10 Years	1,214	72
73	Fully Depreciated Assets				0			73
74					0			74
75	TOTALS	$ 43,476	$ 16,038	$ 3,134	$ (12,904)		$ 4,094	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$ 0		$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 0	$ 0	$ 0	$ 0		$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 133,498	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 16,917	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 4,307	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (12,610)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,272	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number CHICAGO RIDGE NURSING CENTER # 0045815 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Chicago Ridge Real Estate L.P.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		231	11/01/01	$ 769,649	30	30	3
4	Additions							4
5								5
6								6
7	TOTAL		231		$ 769,649 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: [ ] YES [X] NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning 11/01/01
Ending 10/31/31

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2003	$ 1,018,805
13.	12/31/2004	$ 1,060,964
14.	12/31/2005	$ 1,103,121

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 1,850 Description: Minolta Business Solutions - Copier $185 * 10 Months.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number CHICAGO RIDGE NURSING CENTER # 0045815 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER AIDE ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			77,223			77,223	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				48,563		48,563	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Medical Supplies / Rentals Other (specify):	39-2					16,188		16,188	13
14	TOTAL			$		$ 77,223	$ 64,751		$ 141,974	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number CHICAGO RIDGE NURSING CENTER # 0045815 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (289,232)	$ (289,232)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,485,371	1,485,371	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	107,785	107,785	6
7	Other Prepaid Expenses	308,925	308,925	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,612,849	$ 1,612,849	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	90,022	90,022	15
16	Equipment, at Historical Cost	43,475	43,475	16
17	Accumulated Depreciation (book methods)	(17,379)	(17,379)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 116,118	$ 116,118	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,728,967	$ 1,728,967	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 34,350	$ 34,350	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	19,076	19,076	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Management Fees	212,772	212,772	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 266,198	$ 266,198	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 0	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 266,198	$ 266,198	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,462,769	$ 1,462,769	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,728,967	$ 1,728,967	48

*(See instructions.)

Facility Name & ID Number CHICAGO RIDGE NURSING CENTER # 0045815 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 170,709	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 170,709	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,692,060	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(400,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,292,060	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,462,769	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,474,779	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,474,779	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	54,773	6
7	Oxygen	60,208	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 114,981	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Vending Commissions	2,925	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,925	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,592,696	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,184,219	31
32	Health Care	2,184,411	32
33	General Administration	1,076,347	33
	B. Capital Expense		
34	Ownership	1,187,212	34
	C. Ancillary Expense		
35	Special Cost Centers	141,974	35
36	Provider Participation Fee	126,473	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,900,636	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,692,060	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,692,060	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CHICAGO RIDGE NURSING CENTER # 0045815 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,550	1,550	$ 45,949	$ 29.64	1
2	Assistant Director of Nursing	2,737	2,857	73,241	25.64	2
3	Registered Nurses	18,860	19,847	470,917	23.73	3
4	Licensed Practical Nurses	21,366	22,344	441,899	19.78	4
5	Nurse Aides & Orderlies	82,536	87,105	844,191	9.69	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,145	1,161	13,926	11.99	8
9	Activity Director	346	346	6,133	17.73	9
10	Activity Assistants	9,493	10,212	93,797	9.18	10
11	Social Service Workers	3,857	3,997	49,200	12.31	11
12	Dietician					12
13	Food Service Supervisor	1,305	1,328	26,075	19.63	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,571	24,685	188,921	7.65	15
16	Dishwashers					16
17	Maintenance Workers	4,175	4,205	109,466	26.03	17
18	Housekeepers	20,436	21,194	141,709	6.69	18
19	Laundry	10,480	11,180	109,525	9.80	19
20	Administrator	4,160	4,160	131,346	31.57	20
21	Assistant Administrator	2,356	2,356	73,598	31.24	21
22	Other Administrative	798	798	85,145	106.70	22
23	Office Manager	242	242	13,623	56.29	23
24	Clerical	1,498	1,498	27,957	18.66	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,325	1,341	9,853	7.35	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	212,236	222,406	$ 2,956,471 *	$ 13.29	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 10,703	L 1, Col 3	35
36	Medical Director	O			36
37	Medical Records Consultant	N	3,358	L10, Col 3	37
38	Nurse Consultant	T			38
39	Pharmacist Consultant	H	389	L 10, Col 3	39
40	Physical Therapy Consultant	L			40
41	Occupational Therapy Consultant	Y	13,351	L 10A, Col 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	F	8,689	L 10A, Col 3	43
44	Activity Consultant	E			44
45	Social Service Consultant	E	6,536	L 12, Col 3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 43,026		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number CHICAGO RIDGE NURSING CENTER # 0045815 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Doreen Murthy	Administrator	0.00%	$ 86,154
Sue Bassed	Administrator	0.00%	45,192
Marvin Mermelstein	Asst Administrator	50.00%	31,902
David Garcia	Asst Administrator	0.00%	41,696
Barry Taerbaum	Administrative	25.00%	35,000
Henry Mermelstein	Administrative	0.00%	24,892
Joseph Mermelstein	Administrative	25.00%	25,253
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 290,089

B. Administrative - Other

Description	Amount
Nivram Mgmt Inc - Management Fees	$ 21,669
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 21,669

C. Professional Services

Vendor/Payee	Type	Amount
		$
See Attached Schedule		70,331
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 70,331

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 102,580
Unemployment Compensation Insurance	37,901
FICA Taxes	194,930
Employee Health Insurance	46,067
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits - Other	14,234
Allocation from Management Company	17,355
TOTAL (agree to Schedule V, line 22, col.8)	$ 413,067

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	23,266
Health Care Worker Background Check	156
(Indicate # of checks performed)	
IL Council on Long Term Care	15,184
Village of Chicago Ridge	1,552
HCFA Laboratory Serv.	150
Division of Management Serv.	140
Non Deductible Dues	(3,521)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(317)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 36,610

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	355
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 355

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CHICAGO RIDGE NURSING CENTER # 0045815 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number CHICAGO RIDGE NURSING CENTER # 0045815 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council Long Term Care $15,184**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **N/A** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **126,473**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees